CHAGRIN COUNSELING ASSOCIATES
& EATING RECOVERY

CLIENT INFORMATION SHEET

Date____________

How were you referred to this office?____

NAME____

PARENT'S NAME (if minor)____

ADDRESS____

CITY________________________ STATE_________ ZIP______________

DATE OF BIRTH____________________ AGE___________ SEX: M F (circle)

SOCIAL SECURITY #________________ MARITAL STATUS: S M SEP D W
(circle)

HOME PHONE______________________ WORK PHONE_____________________

CELL PHONE_______________________ May we contact you at: Home, Work, Cell
(circle any)

EMAIL ADDRESS___________________

IN CASE OF EMERGENCY, PLEASE CONTACT___________________________________

PHONE:___________________ RELATIONSHIP TO CLIENT______________________

MEDICATIONS?___________________________________ ALLERGIES? Y N (circle)

Primary Care Physician ______________________________ PHONE:__________________